IT IS TIME TO CHANGE THE FACE OF METHADONE MAINTENANCE.

Methadone Maintenance is a medical treatment, yet many physicians have a limited and peripheral role in some programs. Many MMT (Methadone Maintenance Treatment) physicians are not adequately trained in the practice of addiction medicine and lack a thorough working knowledge of the laboratory and clinical research that forms the basis for medical treatment. This is of major concern to patients and an embarrassment for some of the providers who do value quality care.

Unfortunately at this time there is no "real" standard of patient care. Not only are there differences from one state to another, there are broad differences among clinics in a single city or state. Regarding differences among the states, some do not permit MMT to be practiced, at all.
While one clinic may offer quality care represented by adequate dosing practices and providing counseling on an as needed basis, another may offer only mistreatment, with forced counseling and inadequate medication doses. It is sometimes impossible for patients to travel or relocate due to the absence of services or the primitive character of the MMT that is offered. In many instances this causes patients to lose jobs or turn down promotions that would allow them and their families a better quality of life.

There must be some minimum standard that clinics and doctors must follow while at the same time allowing for individualized care. All this must be done without placing an undue financial burden upon either the provider or the patient.

TexNAMA hopes that new accreditation process will allow for individualized treatment and a higher standard of care. Yet, at the same time we are afraid that MMT could end up worse than it is if too much unnecessary paperwork and documentation is placed upon the provider. TexNAMA supports adequate methadone dosing of patients. This means that each person has a different requirement and this should be determined by the physician and patient working together and not by some bureaucratic intervention by non medical bodies. The present system of dosage caps and non-interest in the patient's needs does not meet that standard.

Each patient is an individual and requires individualized prescription treatment, counseling, and dosing. What is considered by some to be quality care (i.e., forced "counseling " sessions which must go on, forever) can become the patient and providers nightmare. It is rare that any kind of patient needs weekly counseling for anything for their whole life. A patient who is stable, and has no desire for "counseling," and has more productive ways to spend their time, is still forced to attend sessions called "counseling and group therapy," is more likely to leave treatment. "Counseling" should be reserved for those who need it and/or want it. It should not be a global standing order for all comers, day in and day out, for year after year with no end in sight. It is clinically and fiscally irresponsible to do so. This also causes and undue financial burden upon the patient and the provider.

98N-0617

C21

TEXNAMA • 6134 Rose Valley • San Antonio, TX 78242 • (210) 623-3664 • Fax (978) 246-6510

TexNAMA has deep concerns about the new accreditation process. One of them involves the potential for raising the cost of treatment. If too many useless and costly tasks are heaped upon clinics and physicians we fear that some will be forced to close their doors. If there are less clinics, those that survive will be able to charge whatever they want, thus raising the price of treatment which at this time can be as high as $100+ per week. This will in no way help the patient. It may also stop those who need it most from seeking treatment, as well as placing those in treatment in a situation that could in some cases, cause them to leave treatment and/or lower their standard of living.

Enforcement. Will the new accreditation standards supersede what exists now or just be added complication without benefit? Clinics are allowed to charge whatever they want, set arbitrary dosage limitations and make ridiculous rules that make it almost impossible for a patient to obtain and keep employment. Will accreditation change this? Or will clinics still be allowed to change or enforce arbitrary rules whenever the counselor has a "bad" day or has a personality conflict with a particular patient?

Takehomes/Urines. What if a state decides, contrary to many studies that show that daily dosing is of little benefit, do not allow for 31 day takehomes. Will there be any recourse for the patient? Who will stand up for the person served if the clinic decides that they want daily, weekly or monthly urine screening despite a patients long record of clean urines? If they decide to test for other drugs such as; alcohol, nicotine and marijuana who will benefit? (The drug testing companies would be our first guess, certainly not the patient or provider.) If a patient who has been in treatment for many years, and living a productive life loses their present takehome status just because they had a few drinks the night before, or attended a concert where marijuana was everywhere.

Benefits to the patient/person served. Will the new accreditation be able to protect the rights of the patient while at the same time allowing the patient to be a part of their own treatment plan? TexNAMA fears that the clinics will continue to pay lip-service to the patients needs when preparing a comprehensive treatment plan. There is also the fear that when the patient moves from one locality to another that they will not receive a continuity of care, i.e., be allowed to keep their present attendance schedule and dosage.

In summary TexNAMA is concerned with not only the quality of treatment but the availability of treatment. We would like to see methadone treated the same as other treatment modalities. Methadone should be integrated into the continuum of medical, psychiatric and addiction treatment. Regulation should be tailored to result in practice based upon sound medical standards. New regulations must be specific enough to guarantee that treatment does not fall below an acceptable standard and sufficiently unrestrictive so that the same clinical and administrative freedom that exists in other medical settings results in individualized treatment planning. What we do not need is more paperwork, useless and unnecessary rules and regulations that will make treatment more of a burden to both patient and provider, thus helping no one.

Opioid addiction is a treatable disease and not a moral defect. Please support measures that reflect this simple fact.

TEXNAMA • 6134 Rose Valley • San Antonio, TX 78242 • (210) 623-3664 • Fax (978) 246-6510